ARJ Infusion SERVICES — Specialty Pharmacy and Nursing

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Bamlanivimab | New Patient Enrollment Form

Patient Exclusion Criteria

If a patient meets any of the following criteria, they are not eligible for bamlanivimab infusion therapy:

1.) Currently hospitalized due to COVID-19
2.) Requires oxygen therapy due to COVID-19
3.) Requires an increase in baseline oxygen flow rate due to COVID-19 and on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

1 Patient Information:

Patient Name: ______________________ **Date:** ______________

SSN#: ____________ DOB: ____________ Primary Phone: ____________ Work Phone: ____________

Address: ______________________ City: ____________ State: ________ Zip: ________

☐ NKDA Allergies: ______________________ Ht: ________ in/cm Wt: ________ lbs/kg

☐ Male ☐ Female Date of First Symptom Onset: ____________ COVID Positive Result Date: ____________

2 Clinical Information: *ARJ policies and protocols to be provided upon request.*

Medication	Dose	Directions	Quantity/Refills
☒ Bamlanivimab	700 mg/250 mL NS	Infuse IV per manufacturer guidelines	Dispense: 1x dose No Refills

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure.

☒ **50ml 0.9% Sodium Chloride:** Once infusion is complete, flush infusion line with 50ml 0.9% Sodium Chloride to ensure delivery of required dose.

Inclusion Criteria

At least one of the following criteria must be met to qualifty for bamlanivimab therapy

☐ Patient is 12 years of age or older weighting at least 40 kg

Patient Weight: ____________ kg Date: ____________

Patients must have at least one of the following listed below *(check all that apply)*:

☐ Body Mass Index greater to or equal to 35 ☐ Chronic Kidney Disease ☐ Diabetes

☐ Immunosuppressive Disease (*i.e. CVID*) ☐ Currently receiving immunosuppressive treatment

☐ ≥ 65 years of age ☐ ≥ 55 years of age, **AND** have at least one of the following: Cardiovascular disease, Hypertension, COPD or other respiratory disease

Ages 12-17 AND have at least one of the following:

☐ BMI ≥ 85th percentile for age & gender based on CDC growth charts
Visit website: *cdc.gov/growthcharts/clinical_charts.htm*

☐ Sickle Cell Disease ☐ Congenital or Acquired heart disease

☐ Neurodevelopmental disorder ☐ Medical-related technological dependence (*i.e. tracheostomy, gastrostomy, ventilator and not related to COVID-19)*

☐ Asthma, reactive airway, or other chronic respiratory disease requiring daily medication

Adverse Reaction Orders: *(Please choose one)*

☐ **DO NOT DISPENSE:** Facility will use their own reaction medication.

☐ **DISPENSE ARJ REACTION MEDICATION:** Indicated per manufacturer guidelines listed below.

In the event of an infusion reaction (*ie: fever, chills, backache, headache, rigors*) the following orders will be followed and physician will be notified.

Note: For mild reactions, patient may be treated and infusion resumed at a slower rate.

☒ **STOP** infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms:

☒ **Diphenhydramine**
50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes or 50 mg/10 mL NS IV push over 2-3 minutes, as tolerated.

☒ **Methylprednisolone**
125 mg (**OR** ____________ mg) slow IV push over 5 minutes.

☒ **Acetaminophen**
325-650 mg (**OR** ____________ mg) po at onset of symptoms.

☒ **Ondansetron**
4 mg slow IV push over 5 minutes or 4 mg ODT.

☒ **Epinephrine** (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used.

3 Prescriber Information:

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

Physician Name: ______________________ Office Contact: ______________

Address: ______________________ City: ______________

State: ____________ Zip: ________ Phone: ____________ Fax: ____________

License #: ____________ DEA#: ____________ NPI #: ____________

______________________ Date: ________ | ______________________ Date: ________

Physician Signature Required - Substitution Permitted ***Physician Signature Required - Dispense as Written***